PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, February 27, 2001, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Dr. Howard Koh (Chairman), Dr. Clifford Askinazi, Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Mr. Albert Sherman, Ms. Janet Slemenda, Ms. Shane Kearney Masaschi, and Dr. Thomas Sterne; Mr. Benjamin Rubin absent. Also in attendance was Attorney Donna Levin, General Counsel.

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Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A 1/2. In addition, Dr. Koh announced that the docket has been revised to include two staff presentations entitled, "Adolescent Teen Births" and "Adolescent Substance Use: Results of the Triennial Prevalence Survey".

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The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Teresa Anderson, Director, Research and Evaluation, Bureau of Substance Abuse Services; Mr. Saul Franklin, Project Manager, Office of Statistics and Evaluation, Bureau of Family and Community Health and Ms. Sally Fogerty, Assistant Commissioner, Bureau of Family and Community Health; Dr. Paul Dreyer, Director, Division of Health Care Quality; Mr. Paul Jacobsen, Deputy Commissioner, Dept. of Public Health; Ms. Joyce James, Director, and Ms. Holly Phelps, Consulting Analyst, Ms. Joan Gorga, Program Analyst, Determination of Need Program; and Attorney Carl Rosenfield, Deputy General Counsel, Office of the General Counsel.

RECORDS OF THE PUBLIC HEALTH COUNCIL:

Records of the Public Health Council Meeting of August 22, 2000 were presented to the Council for approval. After consideration, upon motion made and duly seconded, it was voted (unanimously): That Records of the Meeting of August 22, 2000 be approved.

PERSONNEL ACTIONS:

In a letter dated January 30, 2001, Linda C. Loney, M.D., Associate Medical Director, John H. Britt, Executive Director, and Arthur M. Pappas, M.D., Chairman, Board of Trustees, Massachusetts Hospital School, Canton, recommended approval of appointments and reappointments to the medical and allied health staffs of Massachusetts Hospital School. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees'qualifications, upon motion made and duly seconded, it

was voted (unanimously): That, in accordance with the recommendation of the Associate Medical Director, Executive Director, and Chairman of the Board of Trustees of Massachusetts Hospital School, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointments and reappointments to the medical and allied health staffs of Massachusetts Hospital School be approved as follows:

PHYSICIAN/DENTAL APPOINTMENTS	**STATUS/SPECIALTY**
Carlton M. Akins, M.D.	Reappointment/Active Orthopedics
Anthony Atala, M.D.	Reappointment/Consultant Pediatric Urology
Elizabeth D. Barnett, M.D.	Reappointment/Active Pediatric Infectious Diseases
Stuart B. Bauer, M.D.	Reappointment/Consultant Pediatric Urology
John Bernardo, M.D.	Reappointment/Active Pulmonary Medicine
Benjamin E. Bierbaum, M.D.	Reappointment/Consultant Orthopedics
Sigurdur Bjornsson, M.D.	Appointment/Provisional Pediatric Infectious Diseases
Joseph G. Borer, M.D.	Reappointment/Consultant Pediatric Urology
Christine L. Campbell-Reardon, M.D.	Reappointment/Active Pulmonary Medicine
Elizabeth Bowe Caronna, M.D.	Appointment/Provisional Pulmonary Medicine
David M. Center, M.D.	Reappointment/Active Pulmonary Medicine
Henry H. Cho, M.D.	Reappointment/Consultant Rehabilitation Medicine

Bartley G. Cilento, Jr., M.D.	Reappointment/Consultant Pediatric Urology
Ellen R. Cooper, M.D.	Reappointment/Consultant Pediatric Infectious Diseases
Thomas Cooper, M.D.	Reappointment/Consultant Dermatology
David A. Diamond, M.D.	Reappointment/Consultant Pediatric Urology
John Emans, M.D.	Reappointment/Consultant Orthopedics
Murray Feingold, M.D.	Reappointment/Courtesy Genetics
John P. Ficarelli, D.M.D.	Reappointment/Active Dental and Oral Surgery
Gerald S. Fine, D.D.S.	Reappointment/Active Dental and Oral Surgery
Alejandro Flores, M.D.	Reappointment/Consultant Pediatric Gastroenterology
Geraldine Garcia-Rogers, D.M.D.	Reappointment/Active Dental and Oral Surgery
Steven W. Greer, M.D.	Reappointment/Courtesy Pediatrics
Sheela Gurbani, M.D.	Reappointment/Active Neurology
Jo-Ann S. Harris, M.D.	Reappointment/Consultant Pediatric Infectious Diseases
Timothy M. Hresko, M.D.	Reappointment/Consultant Orthopedics
Katherine K. Hsu, M.D.	Appointment/Provisional Pediatric Infectious Disease

James M. Kenny, M.D.	Reappointment/Honorary Pulmonary Medicine
Jerome O. Klein, M.D.	Reappointment/Consultant Infectious Disease
Frances J. Lagana, D.P.M.	Reappointment/Consultant Podiatry
David Levoy, M.D.	Reappointment/Active Psychiatry
Linda C. Loney, M.D.	Reappointment/Active Pediatrics and Adolescent Medicine
Julie C. Lumeng, M.D.	Appointment/Provisional Pediatrics
Peiman Mahdavi, D.M.D.	Reappointment/Active Pediatric Orthodontics
Joanne L. Mitchell, M.D.	Reappointment/Active Pediatrics
William J. Morgan, M.D.	Reappointment/Consultant Orthopedics (Hand Surgery)
Trevena B. Moore, M.D.	Appointment/Provisional Pediatrics
Alan L. Morris, D.M..D.	Reappointment/Active Pediatric Periodontics
Nasser Nabi, M.D.	Reappointment/Consultant Cardiology
Arthur M. Pappas, M.D.	Reappointment/Active Orthopedics
Scott F. Petrie, D.M.D.	Reappointment/Active Pediatric Dentistry
Kathryn J. Quinn, M.D.	Appointment/Provisional Pediatric Infectious Diseases

Alan B. Retik, M.D.	Reappointment/Consultant Pediatric Urology
Aruna Sachdev, M.D.	Reappointment/Active Pediatrics, Rehabilitation Medicine
Arthur J. Schneider, M.D.	Reappointment/Consultant Radiology

NURSE PRACTITIONERS:

Sheila Bell, CPNP	Reappointment Pediatrics
Louisa Fertitta, M.S., R.N.C.	Reappointment Gynecology
Kathleen Connolly, M.S., R.N.C.	Reappointment Pediatrics
Karen Wheeler-Madden, M.S., R.N.C.	Reappointment Pediatrics
Barbara Closs, M.S., R.N.C.	Appointment/Provisional Pediatrics

PSYCHOLOGISTS:

John T. Jones, Ph.D.	Reappointment Psychology
Diana L. King, Psy.D.	Reappointment Psychology

Wayne L. Klein, Ph.D.	Reappointment Psychology

PAIN MANAGEMENT:

Isabel M. Balmaseda	Reappointment Acupuncturist
Carolanne Oller-Chiang	Reappointment Massage Therapist

OPTOMETRY:

Cathy Stern, O.D.	Reappointment/Active Optometry

In letters dated February 7, 2001, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the appointments and reappointments to the consultant, active, provisional active, provisional allied and allied medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees'qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointments and reappointments to the various medical staffs of Tewksbury Hospital be approved for a period of two years beginning February 1, 2001 to February 1, 2003:

APPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Mary Aileen Dame, M.D.	Provisional Active Internal Medicine	47572
Una O'Connell, MS, RNC, ANP	Provisional Allied Internal Medicine	88048

REAPPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**

Howard Kairys, Psy.D.	Allied Psychologist	6234
Gauri Bhide, M.D.	Consultant	76591
Walter Levitsky, M.D.	Active	26773

In a letter dated February 12, 2001, Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of appointments and reappointments to the medical and allied health staffs of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees'qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointments and reappointments to the medical and allied health staffs of Lemuel Shattuck Hospital be approved as follows:

PHYSICIAN APPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Heidi Abedelhady, M.D.	Consultant/Internal Medicine	203430
Matthew Curley, M.D.	Consultant/Internal Medicine	206207
Douglas Janowski, M.D.	Consultant/Internal Medicine	203367
Philip McAndrew, M.D.	Consultant/Internal Medicine	158970
Melissa Murphy, M.D.	Consultant/Internal Medicine	160985
Anne Pemberton, M.D.	Consultant/Internal Medicine	158738
Hedy Smith, M.D.	Consultant/Internal Medicine	203148
Kevin Tally, M.D.	Consultant/Internal Medicine	205327

Shirly Tozzi, M.D.	Consultant/Internal Medicine	158360

PHYSICIAN REAPPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Stephen Wright, M.D.	Active Gastroenterology	34464
Onsy Yousef, M.D.	Active Anesthesiology	36319

ALLIED HEALTH PROFESSIONAL – APPOINTMENT	**SPECIALTY**	**MEDICAL LICENSE NO.**
Christopher Manning, N.P.	Internal Medicine	205286
Mary Keohane, N.P.	Internal Medicine	155670

In a letter dated February 5, 2001, Blake Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of a reappointment of a physician (Kollegal Murthy, M.D.) to the affiliate medical staff of Western Massachusetts Hospital. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointment of a physician to the affiliate medical staff of Western Massachusetts Hospital be approved:

PHYSICIAN APPOINTMENT	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**

Kollegal Murthy, M.D.	Affiliate/Internal Medicine Oncology/Hematology	56320

In a memorandum dated February 15, 2001, Howard K. Koh, Commissioner, Dept. of Public Health, Boston, recommended approval of an appointment of Craig Ryder to Program Manager V (Deputy Director for Program Operations) Massachusetts Tobacco Control Program. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Craig Ryder to Program Manager V (Deputy Director for Program Operations) Massachusetts Tobacco Control Program be approved.

In a memorandum dated February 15, 2001, Howard K. Koh, Commissioner, Dept. of Public Health, Boston, recommended approval of an appointment of Robert Ryan to Fiscal Officer VI (Director of Administration & Finance) Bureau of Family and Community Health. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Robert Ryan to Fiscal Officer VI (Director of Administration & Finance) Bureau of Family and Community Health be approved.

STAFF PRESENTATIONS:

"ADOLESCENT TEEN BIRTHS"

Mr. Saul Franklin, Project Manager, Office of Statistics and Evaluation, Bureau of Family and Community Health, presented a summary of the recently released publication entitled, "Adolescent Births: A Statistical Profile, Massachusetts 1999", to the Council. Assistant Commissioner Sally Fogerty, Bureau of Family and Community Health, followed Mr. Franklin, explaining the various programs the department has to combat teen pregnancy. Some statistics from the report follow:

Teen Birth Rate:

- In 1999, there were a total of 5,588 births to Massachusetts resident women under the age of 20, a decrease of 314 teen births from the previous year.

- The1999 Massachusetts teen birth rate (births per 1,000 women ages 15-19 years) was 26.6, this rate was 46% lower than the 1999 national rate of 49.6.

- The teen birth rate in Massachusetts has declined between 1994 and 1999, dropping from 33.2 to 26.6 births per 1,000 women ages 15-19. The national teen birth rate also declined, from 58.9 in 1994 to 49.6 in 1999.

- In 1998, 6.9% of all births were to teen mothers (less than 20 years of age). The Massachusetts percentage was well below the 1999 national percentage (12.2%).

Infant Mortality Rate:

- The 1998 infant mortality rate (number of deaths among infants less than one year old per 1,000 live births) among births to Massachusetts teen mothers was 7.3, compared to 4.7% for mothers ages 20 and older (1998 is the most recent data available for infant mortality by mother's age).

- Among teens, the infant mortality rate varied by race/Hispanic ethnicity in 1998. The highest infant mortality rate occurred among births to black non-Hispanic teen mothers (9.4 deaths per 1,000 live births) followed by births to Hispanic teens (7.9) and white teens (6.8).

Prenatal Care:

- In 1999, 64.7% of teen mothers started prenatal care in the first trimester compared with 85.7% of older women. The current Massachusetts percentage of teen mothers starting prenatal care in the first trimester is similar to the 1998 Massachusetts percentage (66.4%).

- The percentage of teen mothers whose prenatal care was supported through public funds in 1999 was 71.6%, higher than 68.5% in 1998. In contrast, 22.8% of women ages 20 and older had prenatal care supported through public funds in 1999.

Smoking:

- The percentage of teen mothers in Massachusetts who smoked during pregnancy was 20.3% in 1999, compared to 21.1% in 1998. In contrast, 10.0% of mothers ages 20 and older in Massachusetts smoked during pregnancy in 1999.

Low Birthweight:

- The percentage of low birthweight infants born to Massachusetts teen mothers was 9.0% in 1999.

- The occurrence of low birthweight infants born to teen mothers in Massachusetts continued to differ among racial and ethnic groups. The percentage of low birthweight infants was lowest among white non-Hispanic teens (8.0%) and highest among Asian teens (11.6%). The percentage of low birth weight among Hispanic and black non-Hispanic teens was 9.3% and 11.3% respectively.

Marital Status:

- In 1999, 91.1% of teen women giving birth were unmarried, virtually unchanged from 90.7% in 1998.

Paternity Acknowledgment:

- Massachusetts has an active program (conducted jointly by the Department of Revenue and Department of Public Health) to promote paternity acknowledgment for out-of-wedlock births. In hospital paternity acknowledgment for out-of-wedlock births remained relatively stable between 1998 and 1999 among births to younger unmarried teens (12-17 years old) from 61.5% to 62.9% and among births to older teens (18-19 years old) from 67.0% to 67.5%.

Technical Notes on above statistics:

- Due to a recalculation of the Massachusetts population estimates in June 1997 by the Massachusetts Institute for Social and Economic Research, the teen birth rates for 1991-1995 given here are different from previously published rates for those years.

- Information taken from Registry of Vital Records, MDPH, BHRSE, 1999 or Curtin SC, et al. Births: Preliminary Data for 1998. National Vital Statistics Report; vol. 48 no. 14. National Center for Health Statistics, August 2000.

- Low birthweight is less than 2500 grams or 5.5 pounds.

NO VOTE/INFORMATION ONLY

"ADOLESCENT SUBSTANCE USE: RESULTS OF THE TRIENNIAL PREVALENCE SURVEY":

Dr. Teresa Anderson, Ph.D., Director, Research and Evaluation, Bureau of Substance Abuse Services, presented the results of the triennial prevalence survey on adolescent substance use. Dr. Anderson said in part, "…This morning's presentation will describe the results of our survey of Massachusetts students in grades six through 12. This study, which was begun in 1984, is conducted every three years with the cooperation of the Department of Education…This Triennial Prevalence Survey is done to assess the prevalence of adolescent substance abuse. We want to assess change in use over time. We want to compare the results with other studies and we also want to note the implication for our future prevention efforts. This study has been conducted every three years since 1984, and this is the sixth data collection effort. During the 1999 to 2000 school year, 6,980 students participated in this study. Classrooms were randomly selected across the Commonwealth and identified by schools. The schools were then contacted and asked if the students could participate in this survey. In all, 169 schools in 106 communities participated in this study. School information remains confidential. The students who participated are totally anonymous. They are not identified in any way in our results. Copies of

today's presentation will be made available to the schools after we are done today. Let's look first at grade six. This is the second time in the course of this study that grade six has been sampled. Looking at the difference in alcohol use in grade six as in 1996, both lifetime and current use has declined. Sixty-five percent of grade six students in 1999 did not use alcohol. This compares with forty-nine percent of students in 1996. Similarly, ninety-two percent of students in grade six report no use in the last thirty days, as compared with eighty-seven percent who responded in 1996. Overall, eighty-nine percent reported they would not use alcohol during the next year. We see a steady decline in lifetime alcohol use in grades seven and eight since 1993. These reports of lifetime alcohol use are the lowest ever reported since the survey was begun in 1984. A steady decline in reported lifetime use began in 1993 and the following results confirm this trend. The reported intention to use alcohol has also declined since 1993 and the reported ease of obtaining alcohol has also declined since 1993."

Dr. Anderson continued, "…The good news here is that lifetime and current use of alcohol has declined for both genders and this is the lowest lifetime alcohol use ever recorded in the survey for both genders in grades seven and eight. Overall, there is a higher proportion of boys who are using than girls. ..We are pleased to say that lifetime alcohol use in high school has declined – the lowest ever reported in this survey. Twenty percent of students in high school have never used alcohol in their lifetime. In Massachusetts, adult alcohol use is among the highest in the nation so we want to congratulate the high school students who resist using alcohol through secondary school…Lifetime alcohol use among both genders declined over the last three years but among high school boys current alcohol use continues to rise. Many research studies report that an early age of first use of alcohol is associated with heavy alcohol use and possible addiction later in life. Although many adults can drink responsibility and safely, research tells us that people who begin drinking in early adolescence are more likely to develop alcohol dependence and are also more likely to be injured. The average age of first use has risen by almost one calendar year, from 11.4 in 1996 to 12.3 this year. This is a very significant finding for our survey. The Healthy People 2010 goals call for us to increase this average over the course of a ten year period. We have realized almost a full year in the past three years. We also saw a change in the distribution of the age of first use. The proportion of the youngest students, those who begun using at nine or younger has dropped dramatically from 31% in 1996 to 16 percent in 1999."

"To summarize the alcohol findings," said Dr. Anderson, "Alcohol is the most frequently reported drug used among all grade levels and it is important to remember that, for these students, it is an illegal drug. Overall, more male than female students report using alcohol. The proportion of students who have never used alcohol has increased since 1996. The average age of first use of alcohol is occurring later and the proportion of students in all grades reporting that it is easy to obtain has dropped since 1996."

Dr. Anderson spoke next about use of five illegal drugs (marijuana, inhalants, MAMA [ecstasy], Ritalin, and heroin). In summary, she said, "Our findings on other drugs is over half of students reported never having used a drug other than alcohol in their lifetime. Overall, drug use has declined from 1996. There were significant declines reported in the use of inhalants and tranquilizers, and in the use of any drug among all the grades. Marijuana use declined

significantly in the lower grades. Although the prevalence remained low, the use of cocaine, crack, steroids, MAMA, and ecstacy all increased in grades seven through twelve over the last three years, with male students reporting more drug use than female students, with the exception of tranquilizer use in grades seven and eight, where girls showed slightly more tendency to use than boys." In regards to tobacco use, Dr. Anderson noted that the use of cigarette smoking among Massachusetts adolescents declined significantly from 1996 to 1999 as it did nationally. Students also reported that cigarettes are more difficult to obtain in 1999 than they were in 1996. And lastly, in grades seven through twelve, the rates of smoking were similar between males and females.

Dr. Koh, Chairman, stated in part, "…We have documented declines in alcohol use for teenagers, the lowest rates of alcohol use in grades seven and eight that we have ever seen, declining rates of marijuana use, and that is much better than a national trend where those rates are going up. We have witnessed tremendous progress with respect to abusing inhalants and that is the result of the work by the task force and many others who have contributed to this. We obviously have many challenges ahead with respect to club drugs and heroine and other very important, illegal substances. We have an increasing focus on prevention for substance abuse. We fund over forty youth programs. We ask youth to serve as leaders and peers for their fellow youth, and we celebrate the peer leader model very much. We have a very active prevention center program and substance use prevention is one of the priority areas for this whole effort. We have new grants throughout communities through our so-called Mass call efforts that promote the message of prevention…." A brief discussion followed.

No Vote/Information Only

REGULATIONS:

REQUEST FOR ADOPTION OF EMERGENCY REGULATIONS INITIALLY PROMULGATED AT THE DECEMBER 19, 2000 MEETING OF THE PUBLIC HEALTH COUNCIL – 105 CMR 130.000 REGARDING THE DISCONTINUANCE OF ESSENTIAL HEALTH SERVICES:

Dr. Paul Dreyer, Director, Division of Health Care Quality, presented the request for adoption of the essential services regulations on an emergency basis for another 90 days so that the regulations will stay in effect without interruption until the public hearing process is complete. Under 105 CMR 130.122 (D) it states, "In the event that the Department finds that a hospital proposes to discontinue an essential health service, discontinue an essential health service at a campus, or discontinue services entirely at a campus, the Department shall publish a notice of a public hearing in the legal notice section of local newspapers serving residents of the hospital's service area at least 21 days prior to the date of the hearing. The notice shall set forth the name and address of the hospital, briefly describe the proposed modifications in existing services, and indicate the date, time and location of the hearing. The hearing shall take place in the hospital's service area no later than forty-five (45) days prior to the proposed discontinuance date set out in the hospital's notice submitted pursuant to 105 CMR 130.122 (C). At the public hearing, the hospital shall describe the services to be closed, plans for alternate access to the service, and shall

afford the opportunity for interested parties to present their comments on the hospital's proposal."

After consideration, upon motion made and duly seconded, it was voted unanimously [Sherman not present to vote] to approve the request for **Adoption of Emergency Regulations 105 CMR 130.000 Regarding Discontinuance of Essential Health Services**; that a copy be attached and made a part of this record as **Exhibit Number 14,698**; and that a copy of the emergency regulations be forwarded to the Secretary of the Commonwealth. These emergency regulations were initially promulgated at the December 19, 2000 meeting of the Council, however, an extension was necessary so that the emergency regulations remain in effect until the public hearing process is complete. The emergency regulations will return to the Council for final adoption in March or April.

REQUEST FOR ADOPTION OF EMERGENCY REGULATIONS INITIALLY PROMULGATED AT THE NOVEMBER 21, 2000 MEETING OF THE PUBLIC HEALTH COUNCIL – 105 CMR 950.000, CRIMINAL OFFENDER RECORD CHECKS:

Paul Jacobsen, Deputy Commissioner, Department of Public Health, presented the Emergency Criminal Offender Record Checks Regulations to the Council for renewal for an additional 90 days in order to complete the public hearing process. Mr. Jacobsen said in part, "…The Department held a public hearing on January 16 on the regulations that were adopted in November for the purpose of receiving comments. More than sixty people testified at that time and the Department received approximately one hundred and twenty written comments. Given the number of comments and the broad scope of the testimony, Department staff is still in the process of analyzing the issues raised by the testimony. Staff expects to complete its review and propose amended regulations by the March meeting of the Public Health Council. In the meantime, since the initial regulations are due to expire at the end of the month, the Public Health Council is requested to adopt the emergency regulations again to insure that the requirements and the regulations continue to be met."

Chairman Koh, Commissioner of Public Health, added, "The issue of CORI policies and CORI regulations is a health and human service issue. There are fifteen agencies affected, not simply the Department of Public Health. We, here at DPH have had a public hearing, and you heard the Deputy Commissioner just comment on that. I believe we are the first and the only agency that has had a public hearing to date and we heard many important comments there. I understand that other agencies will be having their hearings in the near future and so this is an issue that extends across human services and I have had a discussion with the Secretary as recently as yesterday about the status with respect to public health. There are many issues on the table here, and I would ask that we all aim for a very careful and important balance. On one hand, CORI checks are part of life in our society and the public expects and demands protections especially for vulnerable populations. Just about everybody wants policies protecting young children and the elderly. On the other hand, we need a situation where we build in some discretion and some flexibility. There are people who have gone through some negative life experiences. They have changed their life. They have come out wanting to help others. They can be effective human service counselors and we need to understand that potential as well. As the Deputy

Commissioner has mentioned, our options here are to permanently adopt these emergency regulations, which I do not feel is acceptable, or adopt them for the next ninety days while we continue to take the many comments under advisement and try to move to a better place. I would urge the Council to adopt these regulations for another ninety days while we and other health and human service agencies move through this very important process."

After consideration, upon motion made and duly seconded, it was voted unanimously to approve the **Adoption of the Emergency Regulations [Initially Promulgated at the November 21, 2000 Meeting of the Council] 105 CMR 950.000, Criminal Offender Record Checks**, for another 90 days; that a copy be attached and made a part of this record as **Exhibit Number 14, 699,** that a copy of the emergency regulations be forwarded to the Secretary of the Commonwealth. These regulations will return to the Council for final approval within the 90 day period.

DETERMINATION OF NEED PROGRAM:

REQUEST FINAL ADOPTION OF THE PROPOSED REVISIONS TO THE SEPTEMBER 1985 CHRONIC DISEASE HOSPITAL REPORT AND AUGUST 1992 DETERMINATION OF NEED GUIDELINES FOR ACUTE INPATIENT REHABILITATION SERVICES:

Ms. Joyce James, Program Director, said in part, "We are seeking final adoption of proposed revisions to the Determination of Need Guidelines for Chronic Disease and Acute Inpatient Rehabilitation Services. The guidelines will remain effective for twelve months following adoption and during that period any facilities that have been determined to be operating at or above capacity will be allowed a single increase in beds, in available space at the hospital's main site. The costs of adding these beds must remain below the Determination of Need minimum expenditures. Generally, any facilities that transfer beds six month prior to or any time following adoption of these guidelines will not be eligible for these beds. The proposed revisions were developed with assistance from a technical advisory group convened by the Department. The membership list of the advisory group is also attached to your memorandum. During the public comment period, five people submitted comments - Three opposing and two in support. Those opposing the guidelines recommend that adoption be delayed until the Department completes a comprehensive bed need analysis. Our response is that the guidelines provide an interim measure to meet an immediate demand until the Department completely reassesses the bed need methodology for both services within the twelve months following their adoption."

Ms. James continued, "Based on other comments, two major changes were made to the guidelines. The 18 month period (moratorium) on the development of satellites was reduced to twelve months. The 85% occupancy rate for capacity expansion was increased to ninety percent. There were also some technical changes which, with these two changes I just mentioned, are summarized on page 8 of your memorandum."

Dr. Paul Dreyer, Director, Division of Health Care Quality, added, "I'd like to make another change to the guidelines by way of clarification: Measure 5, Exhibit A, add the language that

says 'provided that a transfer of beds from an existing satellite to a new satellite may be permitted if the transfer does not result in a net increase in satellite beds, the transferred beds are operational at the time the transfer of site application is filed, and the transfer otherwise meets the provisions of 105 CMR 100.720.' What we are saying is – if the beds are operational at a satellite at the time that the applicant files a transfer of site application, then a transfer of beds from one satellite to another satellite can be approved."

After consideration, upon motion made and duly seconded, it was voted: (Chairman Koh, Ms. Cudmore, Mr. George, Jr., Ms. Kearney Masaschi, Mr. Sherman, Ms. Slemenda, and Dr. Sterne in favor [Dr. Askinazi recused himself and Mr. Rubin absent] to approve the request for **Final Adoption of the Proposed Revisions to the September 1985 Chronic Disease Hospital Report and August 1992 Determination of Need Guidelines for Acute Inpatient Rehabilitation Service** with Dr. Dreyer's addition as stated above; and that a copy be attached and made a part of this record as **Exhibit No. 14,700**.

COMPLIANCE MEMORANDUM:

PREVIOUSLY APPROVED DoN PROJECT NO. 1-1393 OF PROVIDENCE CARE CENTER OF LENOX – REQUEST TO INCREASE THE FINAL INFLATION-ADJUSTED MAXIMUM CAPITAL EXPENDITURE:

Ms. Joyce James, Program Director, Determination of Need Program, presented the request by previously approved DoN Project No. 1-1393 of Providence Care Center of Lenox for an increase in the final inflation adjusted maximum capital expenditure. Ms. James said in part, "…In reviewing the holder's request for the increase, Staff has examined whether the requested additional costs were reasonable in light of past decisions, were not foreseeable at the time the application was filed and were beyond the holder's control. Consistent with the Council's past decisions, staff finds that the additional costs were reasonable, could not have been reasonably foreseen and were not reasonably with the control of the holder Staff recommends approval with a condition."

Staff's analysis states,"The holder is requesting an additional increase of $1,153,574 (June 1999 dollars) above inflation. This increase includes land costs of $46,797 and construction costs of $1,112,183. The $46,797 figure includes $41,557 for land acquisition and $5,240 for site survey and soil investigation. The construction costs include $581,794 for building acquisition, $252,542 for construction contract, $44,499 for asbestos removal and interior design, $180,137 for net interest expense during construction, $55,078 for major movable equipment, less $1,867 for pre- and post-planning and development costs. There was a $5,406 decrease in financing costs. Supporting documentation submitted by the holder indicates that these cost increases were unusual and unforeseen at the time the application was filed. For example, it was after renovation of the building had begun that the building inspector of the town of Lenox required installation of an elevator to comply with the local building code. This required site and soil investigation to build a foundation for installation of the elevator. The building inspector also required additional construction and renovation to the exterior and interior walls of the building to comply with the February 28, 1998, 6th edition State Building Code. Land and building

acquisition costs were omitted from the MCE in the originally filed application. The holder assumed that prior use of the land and buildings as a licensed nursing facility was sufficient for the capital costs of the land and building to be recognized by the Division of Health Care Finance and Policy for rate setting purposes. However, the Division's policies require that land and building acquisition costs must be included in the MCE approved by the Department in order for the Division to establish appropriate Medicaid rates for the replacement facility. A purchase and sale agreement and other supporting documentation were submitted for the land and building acquisition costs."

Staff's analysis stated further that, "The increase in the major movable equipment costs were to satisfy Medicare's requirement that certified facilities must offer rehabilitation services. The asbestos abatement and ledge removal were necessary for installation of the elevator. The interior design includes interior finishing, window treatment, furniture plans, which were necessary for renovation of the building. Regarding the request for net interest expense, the holder reports that the original MCE filed with the application did not include capitalized interest because the corporate parent believed that since the project involved only renovation, financing would be through a short-term, interest free, inter-company loan. However, the new construction required for compliance with local and state building codes and the delay which extended the construction period increased the capital costs so that internal funding was no longer an option. Consequently, the corporation may seek external financing through tax-exempt bonds. The holder also reports that during this period, Sisters of Providence became a member of Catholic Health East, which changed the overall corporate charter and organizational structure by charging interest on inter-company borrowing to reflect the allocation of the costs of funds. Therefore, even with inter-company financing net interest expense would be required."

After consideration, upon motion made and duly seconded, it was voted unanimously to approve with a condition, the request by **Previously Approved Application No. 1-1393 of Providence Care Center of Lenox** for an increase in the final inflation-adjusted maximum capital expenditure, based on staff findings. As approved this amendment provides for in increase in the final inflation-adjusted MCE to $3,803,656 (June 1999 dollars), itemized below. The MCE is for 27,154 gsf of which 1,877 gsf is for new construction and 25,277 for renovation. The approved MCE and gsf do not include the space and construction costs for the 12 DoN-exempt beds.

Land Costs:

Land Acquisition Cost	$	41, 557
Site Survey and Soil Investigation		5,240
Total Land Costs		46,797

Construction Costs:

Building Acquisition Cost	581,794
Construction Contract (including bond cost)	2,644,641
Fixed Equipment Not in Contract*	-
Architectural & Engineering Costs*	-

Pre- & Post-filing Planning & Development Costs		4,987
Other: Asbestos Removal		47,522
Other: Interior Design		11,636
Net Interest Expense During Construction		180,137
Major Movable Equipment		262,147
Total Construction Costs		3,732,864
Financing Costs:		
Costs of Securing Financing		23,995
Total Financing Costs		23,995
Total Estimated MCE	$	3,803,656

*Included in the construction contract

This amendment is subject to the following condition:

1) All conditions attached to the original and amended approval of this project shall remain in effect.

CATEGORY 1 APPLICATION:

PROJECT APPLICATION NO. 4-3958 OF THE GENERAL HOSPITAL CORPORATION D/B/A MASSACHUSETTS GENERAL HOSPITAL TO ADD 2 BEDS TO ITS NEONATAL INTENSIVE CARE UNIT FOR A TOTAL OF 14 BEDS:

For the record, Drs. Askinazi and Sterne recused themselves from discussion and vote on this item (4-3958) of Massachusetts General Hospital.

Ms. Holly Phelps, Consulting Analyst, Determination of Need Program, presented the Massachusetts General Hospital's application for two neonatal beds to the Council. Ms. Phelps stated, "…MGH is proposing to add two neonatal ICU beds to create a 14-bed neonatal intensive care unit. The maximum capital expenditure for the project is about $223,000 and the estimated incremental operating costs for those two beds is about $526,000. The project has been reviewed under the January 1997 updated neonatal intensive care unit guidelines and it complies with one of the requirements which is to have at least 90% occupancy in the beds for the immediate three years and all other requirements of the guidelines. MGH is proposing to contribute $60,000 over the next five years to help support a youth program in Charlestown, and the staff is recommending approval of the project with the single condition that it would fulfill its requirements for the community health initiative…."

Council Member Sherman asked how the 90% occupancy would be met for the two additional beds. Ms. Phelps replied that through the increase in their OB service, their community hospital network and their invitro fertilization program which are expected to produce more infants that require NICU care.

After consideration, upon motion made and duly seconded, it was voted: (Chairman Koh , Ms. Cudmore, Mr. George, Jr., Ms. Kearney Masaschi, Mr. Sherman and Ms. Slemenda in favor (Drs. Askinazi and Sterne recused and Mr. Rubin absent) to approve **Project Application No. 4-3958 of The General Hospital Corporation d/b/a Massachusetts General Hospital**, based on staff findings, with a maximum capital expenditure of $223,046 (June 1998 dollars) and estimated first year operating costs of $526,499 (June 1998 dollars). As approved, the application provides for the addition of two Neonatal Intensive Care Beds for a total of 14 beds located at the Massachusetts General Hospital, 44 Fruit Street, Boston. This Determination is subject to the following condition:

1) The applicant shall provide $60,000 (June 1998 dollars) over a five-year period ($12,000 annually) for the expansion of the YouthCare Program serving special needs children in the Charlestown community. The funding will help provide for an afterschool teacher who would focus on the social, emotional, and behavioral needs of the adolescent girls in the program.

Staff's recommendation was based on the following findings:

1) The applicant is proposing the addition of two (2) Neonatal Intensive Care beds to create a 14-bed NICU service.

2) The health planning process for this project was satisfactory.

3) Consistent with the 1997 revised Determination of Need Guidelines for Neonatal Intensive Care Units (Guidelines), the Applicant has demonstrated need for the two Neonatal Intensive Care Unit beds (see the health care requirements factor of the staff summary).

4) The project meets the operational objectives factor of the Guidelines.

5) The project meets the standards compliance factor of the guidelines.

6) The recommended maximum capital expenditure is reasonable compared to similar, previously approved projects.

7) The recommended incremental operating costs are reasonable based on similar, previously approved projects.

8) The project is financially feasible and within the financial capability of the applicant.

9) The project meets the relative merit requirements of the Guidelines.

10) The Division of Health Care Finance and Policy submitted no comments on the proposed project.

11) The proposed community health service initiatives are consistent with DoN Regulations with a condition.

CATEGORY 2 APPLICATION:

PROJECT APPLICATION NO. 6-1416 OF JEWISH REHABILITATION CENTER FOR THE AGED for substantial renovation to the facility, new construction to replace 20 beds and expand administrative, dining and food handling areas and add 3 DoN-exempt beds:

Ms. Joan Gorga, Program Analyst, Determination of Need Program, presented Project Application No. 6-1416 to the Council. Ms. Gorga said, "… Jewish Rehabilitation Center for the Aged of the North Shore, Inc. located in Swampscott is before you today seeking approval for renovation and new construction of an addition to replace twenty beds and add three DoN exempt beds. The new addition will also allow for the expansion of administration space, as well as food handling and dining space. A public hearing was requested by a Ten Taxpayer Group (TTG) who are neighbors of the rehabilitation center. The public hearing was held at he Swampscott Public Library on November 13 and was attended by five people. The spokesperson for the TTG spoke at the hearing, as did the representatives of the applicant – the applicant's architect and administrator of the nursing home. The comments of the TTG include concerns about the length of time for the construction and the impact on close neighbors. No written comments were received. The applicant indicated that the project would take about a year since it must be done in phases to minimize disruption to the residents. In response to the TTG comments, staff has noted in the staff summary the TTG's concerns about the impact on the neighborhood and has emphasized that it is staff's expectation that the applicants will consider the neighbors during the implementation of the project. In conclusion, staff recommends approval of the application, Project No. 6-1416, with the conditions as indicated in the staff summary, which have been agreed to by the applicant. Staff would be glad to answer questions on the project. The applicant is here to answer questions from the Commissioner or the Council and a representative of the TTG may be here."

After consideration, upon motion made and duly seconded, it was voted: (Chairman Koh , Ms. Cudmore, Mr. George, Jr., Ms. Kearney Masaschi, Mr. Sherman and Ms. Slemenda, and Dr. Sterne in favor (Dr. Askinazi recused and Mr. Rubin absent) to approve **Project Application No. 6-1416 of Jewish Rehabilitation Center for the Aged, of 330 Paradise Road, Swampscott, MA,** based on staff findings, that a copy of the staff summary be attached and made a part of this record as Exhibit No. 14,702; with a maximum capital expenditure of $3,008,643 (January 2000 dollars) and first year incremental operating costs of $507,627 (January 2000 dollars). As approved, the application provides for substantial renovation of the 180-bed facility, a 88 Level I/II and 92 Level III bed facility and new construction of an addition to replace 20 beds and expand administrative, food handling, and dining space and addition of three Level II DoN-exempt beds. When the additions and renovations are completed, the facility will contain 183 beds (91 Level II and 92 Level III). This Determination is subject to the following conditions:

1. The applicant shall accept the maximum capital expenditure of $3,008,643 (January 2000 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 752.

2. The applicant shall, prior to construction, sign formal affiliation agreements with at least one local acute care hospital and one local home care corporation that include provisions for respite care services.

3. The applicant shall establish a plan to protect the privacy, health and safety of the residents during the renovation and construction process, and to ensure that they experience as little disruption as possible in their daily routines.

4. The applicant shall ensure that any Medicaid transfers from the old facility to the new addition will continue to receive care until such time that Medicaid certification is obtained.

5. The total approved gross square feet (gsf) for this project shall be 62, 991: 49,715 gsf for renovations to the existing facility; 12,016 gsf for new construction to replace 20 beds and add administrative offices, kitchen, dining and laundry facilities; and three bed expansion which shall be constructed at the applicant's own risk.

6. The applicant shall obtain Medicare certification for its proposed Level II beds.

7. Upon implementation of the project, any assets such as land improvements, or equipment which are either destroyed or no longer used for patient care, shall not be claimed for reimbursement for publicly aided patients.

8. The Department shall reserve the right to conduct a review of the financial feasibility of the project based on the Division of Health Care Finance and Policy's established rates of reimbursement for Medicaid patients at the time final maximum capital expenditures or any adjustments to the final maximum capital expenditures are submitted to the Determination of Need Program for approval in the event that such expenditures exceed the approved maximum capital expenditure. The applicant shall submit a revised Factor Five (Financial Schedules) upon request by the Department. The Applicant is advised that an increase in equity may be necessary to assure the financial feasibility of the project.

Staff' s recommendation was based on the following findings:

1. The applicant is proposing substantial renovation to the 180-bed Jewish Rehabilitation Center for the Aged, a 88 Level I/II and 92 Level III bed facility located at 330 Paradise Road, Swampscott, MA and new construction of an addition to replace 20 beds and expand administrative, food handling, and dining space and addition of three Level II DoN-exempt beds. When the construction and renovation is completed, the facility will contain a total of 183 beds (91 Level II beds and 92 Level III beds).

2. The health planning process for this project was satisfactory.

3. Consistent with the Determination of Need Guidelines for Nursing Facility Replacement and Renovation (Guidelines), the applicant has demonstrated need for substantial renovation of the existing 180-bed facility with new construction as discussed under the health care requirements factor of the staff summary.

4. The project, with adherence to certain conditions, meets the operational objectives factor of the Guidelines.

5. The project, with adherence to a condition, meets the standards compliance factor of the Guidelines.

6. The recommended maximum capital expenditure is reasonable compared to similar previously approved projects.

7. The recommended incremental operating costs are reasonable based on similar, previously approved projects. All operating costs are subject to review by the Division of Health Care Finance and Policy and third party payors according to their policies and procedures.

8. The project, with adherence to a certain condition, is financially feasible and within the financial capability of the applicant.

9. The project meets the relative merit requirements of the Guidelines.

10. The Executive Office of Elder Affairs submitted no comments on the proposed project.

11. The Division of Health Care Finance and Policy submitted comments related to the financial feasibility of this project.

12. The project is exempt from the communitiy health initiatives requirement.

13. The Chris Speropoulos TTG registered in connection with the proposed project and requested a public hearing.

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The meeting adjourned at 11:25 a.m.

Howard K. Koh, M.D., M.P.H.
Chairman

LMH